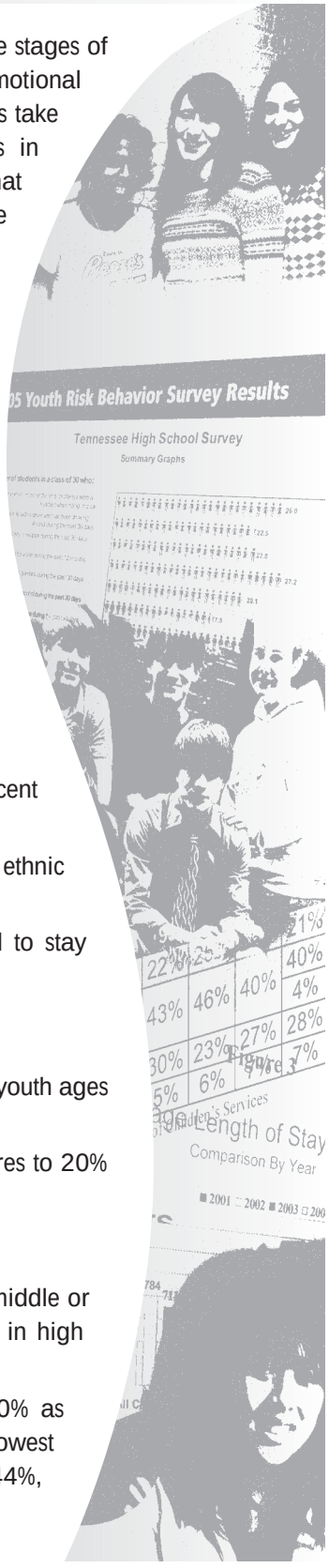
Summary Chapter 1

Fostering Healthy Adolescents and Young Adults

Between the ages of 10 and 20, youth make transitions through early, middle and late stages of adolescence, and each stage brings with it a new set of physical, mental and emotional challenges. While most adolescents successfully navigate this transition, some adolescents take unhealthy or dangerous risks and initiate habits that may lead to chronic illnesses in adulthood. This chapter explores the characteristics of adolescence and the factors that contribute to or detract from a successful transition from child to adult, and introduces the concept of "best practices" that effectively address risky adolescent behavior.

Adolescents' resiliency is influenced by the settings in which they live; their connections to family and friends; and support from community institutions. National surveys of thousands of young people reveal that the more protective factors or assets a young person possesses, then the more likely he or she is to do well in school and less likely to engage in risk-taking behaviors.

The philosophy and approach to policies and programs that incorporate the building of developmental assets and resiliency among youth is called the youth development approach. The underlying philosophy of youth development is holistic, preventive and positive, focusing on the development of assets and competencies in youth as the best means for fostering health and well-being and for avoiding negative choices and outcomes. Youth who succeed in the developmental tasks of adolescence lay the foundation for health and well-being in their adult lives.



Tennessee Data

Population

- In 2004, the population of adolescents, ages 10-19, was 818,681, or 13.9 percent of Tennessee's total population.
- In 2004, 23.2 percent of adolescents, ages 10-19, were of minority racial/ethnic descent, compared to 21.8 percent in 1994.
- The population of adolescents as a percent of the total population is projected to stay relatively stable in Tennessee through 2010.

Economic Status

- In 2000, 71,323 adolescents and young adults (about 15.5% of the population of youth ages 12-17) lived in families with income below the federal poverty level.
- As of 2002, 25% of all 18-24 year old Tennesseans lived in poverty. That compares to 20% nationally.

Education

- During the 2002-2003 school year there were 151,499 adolescents enrolled in middle or junior high schools (7th and 8th grades), and 271,677 young people enrolled in high school (public, private and alternative schools).
- Tennessee ranks 46th in the country with a high school graduation rate of 60% as compared to the rate of 71% for the nation. Hispanic students have the lowest graduation rate of 38%, followed by African-American students with a rate of 44%, and finally a rate of 64% for white students.

- Seventeen percent of Tennessee's young adults ages 18-24 are disconnected young adults, who are defined as young persons either not enrolled in school, not working or do not have a degree beyond high school. Nationally, 15% of America's youth are disconnected young adults.

Best Practices

Best practices are those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying a risky/undesired health behavior or conversely, supporting and encouraging a healthy/desired behavior.

Best Practices for Parents, Peers and Other Adults

- Parent-child relationships are vital to adolescent development and well-being.
- Peer influences are important and can be positive.
- Siblings, teachers and other adults and mentors can provide important support.

Best Practices for Programs

- Young people engaged in programs that build relationships and provide structured activities participate in fewer behaviors that place their health at risk.
- Successful programs target specifically desired outcomes, start early and maintain the effort and implement their services with fidelity to research-tested strategies.
- A positive approach is more likely to engage adolescents and help them to realize their potential and avoid negative influences.

Best Practices for Community Planning

Addressing the health needs of adolescents is best done within the context of community collaboration and planning. These steps assume community and youth involvement.

- Conduct a community-based assessment and planning process to be sure that the community is addressing the adolescent issues that are most appropriate and pressing.
- Decide whether the issue will be addressed directly, or whether the conditions that make it possible will be changed.
- Locate practices or interventions that have successfully addressed the issue in the way the community wants it addressed.
- Determine what elements of a promising intervention will work in the community, and which ones need to be changed.
- Implement the intervention, making on-going adjustments as needed.
- Evaluate the work and results regularly, understanding that no matter how well any intervention works, it can always be improved.

Websites

Annie E. Casey Foundation
www.aecf.org

Assets for Colorado Youth
http://assetsforcoyouth.org/index.html

Center for Adolescent Health and Development
www.allaboutkids.umn.edu/cfahad

Child Trends
www.childtrends.org
Community Toolbox
http://ctb.ku.edu/

Forum on Adolescence, National Research Council and Institute of Medicine
www.nas.edu/nrc

Johns Hopkins Center for Adolescent Health Promotion and Disease Prevention
www.jhsph.edu/hao/cah

National Institute of Mental Health
www.nimh.nih.gov

National Adolescent Health Information Center
http://nahic.ucsf.edu/

National Initiative to Improve Adolescent Health
http://www.cdc.gov/HealthyYouth/AdolescentHealth/NationalInitiative/index.htm

Search Institute
www.search-institute.org

Chapter 1

Fostering Healthy Adolescents and Young Adults

Chapter Preview

This chapter includes a description of:

- Adolescent demographics
- Stages of adolescent development
- State data
- Positive youth development
- Best practices

What is a healthy adolescent or young adult? Healthy adolescents or young adults form caring, supportive relationships with family, other adults and peers; engage in a positive way in the life of their communities; choose behaviors that optimize wellness; demonstrate physical, cognitive, emotional, social and moral competencies; are resilient when dealing with life stressors; show increasingly responsible and independent decision-making; and experience a sense of self-confidence, hopefulness and well-being.[1]

The development of healthy adolescents and young adults is a complex and evolving process that requires supportive and caring families, peers, and communities; access to high quality services; and opportunities for youth to engage and succeed in the developmental tasks of adolescence.[2]

What is it like being an adolescent in 2006? In some ways not too different from what adults experienced when they were this age…negotiating new rules and boundaries with parents, influence of peer pressure and the media, discovering one's sexuality, and trying to figure out who you want to be and how best to make that happen.

What is different about growing up today? Young people live in a very changed environment than what existed 30 years ago. Advanced technologies (cell phones, I-Pods, computers and video games) are available to most adolescents. More youth live in single parent homes or in homes where both parents work. Fast food is readily available and frequently eaten. Youth watch more television and are exposed to more violent programming. Young people as a group are much more diverse. Educational expectations have increased in order to keep up with scientific and technology advances.

Influences of family, school and community affect the healthy development of adolescents. During this time of development, youth transition from early adolescence (ages 10-14), to middle (15-19) to late adolescence/young adult (20-24) stages. Each stage presents a new dynamic of physical, emotional and mental challenges.[3]

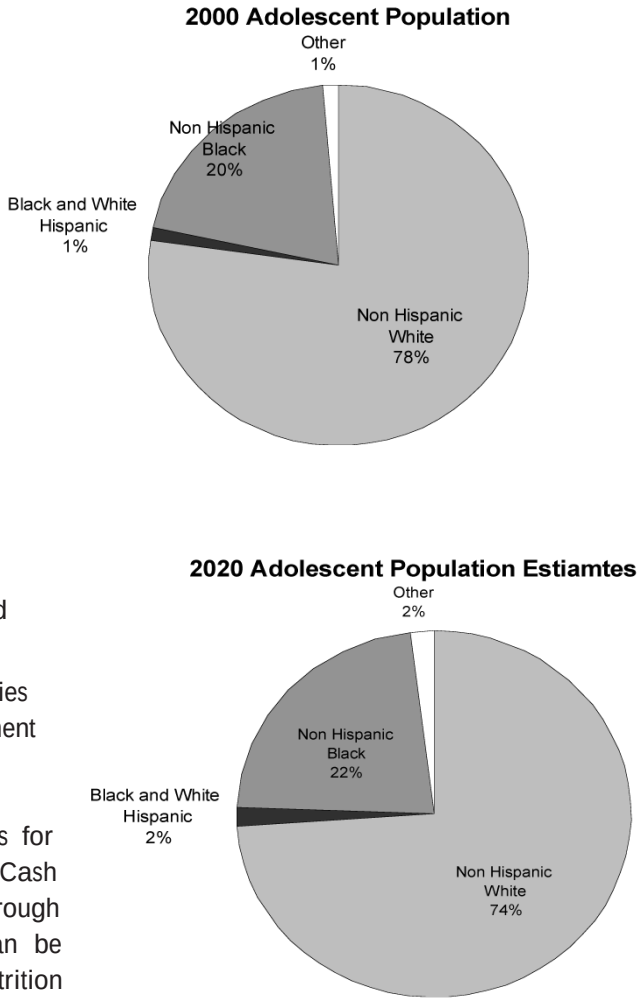
Tennessee Data

Population

- In 2004, the projected population of adolescents and young adults, ages 10-24, was 1,219,077 or 20.7% of Tennessee's total population. Of the total adolescent and young adult population (ages 10-24), 34% are ages 10-14, 33% are ages 15-19 and 33% are ages 20-24. Boys slightly outnumber girls 51% to 49%.[4]
- The population of adolescents as a percent of the total population is projected to stay relatively stable in Tennessee through 2010.[5]

- In 2000, 22.3% of adolescents, ages 10-24, were of minority racial/ethnic descent, compared to 20.4 percent in 1990. Using 2004 population projections, 76.8% of adolescents were white non-Hispanic, 21.6 percent were African-American, and 1.6 percent were "other".[6]

Figure 1
Demography of Tennessee Population, Ages 10-24, 2000 and 2020



Source: U.S. Census Bureau

Economic Security

How many adolescents and young adults face economic hardship in Tennessee?

- In 2000, 71,323 adolescents and young adults (about 15.5% of the population of youth ages 12-17) lived in families with incomes below the federal poverty level.[7] In 2003 the federal poverty level for a family of three was $14,680).[8]
- An estimated 41.4% of adolescents and young adults (age 19 and under) lived in families with incomes below 200 percent of the federal poverty level.[9]
- In October 2003, approximately 67,523 residents ages 10-24 were receiving "welfare" (Temporary Assistance to Needy Families or TANF). This represents 35% of all Tennesseans receiving welfare as of October 2003.[10]
- As of 2002, 25% of all 18-24 year old Tennesseans lived in poverty. That compares to 20% nationally.[11]
- From 1996 to 2001 the percent of children living in families where no parent had full-time, year-round employment increased by 7% in Tennessee.[12]

Many different state and local programs provide services for adolescents and young adults who have low incomes. Cash assistance is available for adolescents who are disabled through Supplemental Social Security Income. Nutrition support can be provided through food stamps, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and free and reduced price school lunch. Health care services can be accessed through TennCare, Title X Family Planning, federal mental health and substance abuse block grants. Housing; child care; and employment training programs are also available.

Family Structure

Tennessee adolescents and young adults live in a variety of family structures.

- In 2001, there were 4,033 youth ages 15-19 living in foster care.[13]
- In 2002, there were 20,284 mothers under the age of 20 living in Tennessee.[14]

- In 2001, there were 1,655 juveniles detained, incarcerated, or placed in residential facilities.[15]

Education

- During the 2002-2003 school year there were 151,499 adolescents enrolled in middle or junior high schools (7th and 8th grades), and 271,677 young people enrolled in high school (public, private and alternative schools).[16]
- Tennessee ranks 46th in the country with a high school graduation rate of 60% as compared to the rate of 71% for the nation. Hispanic students have the lowest graduation rate of 38%, followed by African-American students with a rate of 44%, and a rate of 64% for white students.[17]
- Tennessee has an 11% school drop-out rate among 16-19 year olds compared to 9% as the national average.[18]
- 17% of Tennessee's young adults ages 18-24 are disconnected young adults, which is defined as the young person either not enrolled in school, not working or does not have a degree beyond high school. Nationally, 15% of America's youth are disconnected young adults.[19]
- According to the 2000 Census, the average salary for people over the age of twenty-five with no high school diploma or GED was $12,478 as compared to the average of $20,889 for those who did complete high school or receive a GED.[20]
- According to the Unmet Needs 2001 report, 74% of the state's prisoners failed to complete high school.[21]

Stages of Adolescent Development

There are three main stages of adolescent development: early, middle and late. Each stage brings with it a set of physical, mental, behavioral and emotional characteristics. The different characteristics that take place during each stage are essential to consider when planning youth programs and services. Table 1 summarizes characteristics of adolescent development.

Table 1

Stages of Adolescent Development

Stages of Adolescence	Developmental Task	Description
EARLY Ages 10-14	Adjusting to physical and biological changes	* Positive and negative changes in self image and self-esteem as physical appearance changes; different for boys and girls * Responding and reacting to others' perceptions of them as physical changes occur * Comparing self to peers and worrying about being different
	Developing independence from parents	* Changing relationships with caregivers and adults * Increased need to have an identity apart from the family
MIDDLE Ages 15-17	Developing a new appreciation for peer relationships	* Increased focus on peers for support, companionship and feedback * Adoption of peer lifestyles and codes, including language and dress * Use of peer group as safe haven for testing out decision-making skills, building intimacy and reinforcing self-confidence
	Developing a sense of belonging	* Greater need for: Physical belonging, or feeling connected to home, school, neighborhood and/or workplace * Social belonging or feeling accepted by family, friends and neighbors by taking part in activities and being useful to others * Community belonging, or having access to resources, e.g., social and health services, educational programs and community activities
LATE Ages 18-20	Achieving a sense of independence or autonomy	* Ongoing effort to define themselves and become individuals with their own perspectives * Development of individual values and beliefs, with the ability and interest to think abstractly and plan for the future
	Beginning to master work	* Participation in challenging, skill building activities to boost self-esteem, and life skills for adulthood as well as to enhance employment opportunities and a sense of connection to the larger world

Source: Parents Matter: A Caregiver's Guide to Adolescent Health and Development, Johns Hopkins Center for Adolescent Health Promotion and Disease Prevention (1999).

What Affects the Health of Adolescents?

The health of adolescents is affected by a complex interplay of factors between the young person and their social environment. Their health is shaped by parents and family, peers, neighborhoods and communities, schools, community organizations, faith communities, health care systems, media, employers, governmental agencies, social norms, and policies and laws. These factors impact young peoples' sense of health and well-being by affecting their capacity to withstand life stressors, their ability to transition in developmentally appropriate ways, and their decisions about health behaviors.

Health Behaviors

There are a small number of risk behaviors that negatively affect the health of adolescents. 70% of adolescent death and illness is caused by six categories of risk behavior:

- Behaviors that result in unintentional and intentional injury (including violence and suicidal behaviors)
- Alcohol and other drug abuse
- Tobacco use
- Sexual behaviors that result in unintended pregnancy, HIV infection and other sexually transmitted infections
- Unhealthy dietary behaviors
- Inadequate physical activity

These behaviors increase the likelihood of unhealthy outcomes for teens and are influenced by a complex interplay of factors. They cannot be understood in isolation but must be viewed in the context of a young person's life.

Characteristics of Youth Risk Behaviors

Adolescent risk behaviors have been studied extensively. A large body of research has identified a number of youth risk behavior characteristics:

- Risk behaviors are the result of a complex interplay of numerous factors within a young person's life. No single factor "causes" or explains a risk behavior.
- Most teens are at low risk for these behaviors. They rarely take chances or seriously experiment with risk behaviors. A relatively small percentage of teens concurrently engage in multiple risk behaviors.
- Risk behaviors develop over time and tend to vary by age. Older teens are more likely to be involved in risk behaviors than younger teens.
- Teens are starting risk behaviors at younger ages than in the past. In general, the earlier teens start a risk behavior, the more likely they will experience serious problems later and the more likely they will become involved in other risk behaviors.
- Risk behaviors do not occur in isolation but tend to cluster together in predictable ways. Risk behaviors are often functional.

Although there are costs associated with risk behaviors, young people also experience benefits (gaining peer acceptance and respect; establishing independence; defining a social role; coping with anxiety, stress or failure; etc.).

Risk and Protective Factors within the Social Environment

There are factors within the social environment that impact the health of adolescents by influencing health behaviors, resiliency, healthy development and sense of well-being. There are negative influences (risk factors) and positive influences (protective factors or developmental assets) that affect health.

Risk and protective factors interact together to influence the health of youth. It is not just the presence of factors but more importantly the complex balance and interplay between them that affects health. The relationship between risk and protective factors and health is complex. It is often difficult to determine whether factors are the cause of poor health or simply red flags that indicate other underlying factors. Because of this complexity, easy-fix solutions do not work. At the same time, research and experience provide some clarity about the role of risk and protective factors in health:

- Risk and protective factors reside within all "spheres of influence" that impact the health of youth: the individual adolescent, family, peers, school and community.
- These factors are not static. They can change over time and may have different effects depending on a young person's developmental phase and the presence of other factors.
- The effect of risk and protective factors is cumulative. A single risk factor seldom places a young person in jeopardy; but as a young person encounters more risks, the probability of a poor outcome increases. The same holds true for protective factors.
- While some factors can be changed such as presence of a caring, supportive adult or connectedness to school, other factors, such as poverty, are difficult to change.
- Groups of youth risk behaviors and unhealthy outcomes share risk and protective factors. Risk factors such as child abuse, poor academic achievement, community violence, and protective factors such as family and school connectedness are shared by a variety of youth risk behaviors.[22]

Balanacing Risky Behaviors with Assets

Most adolescents and young adults successfully navigate the risky aspects encountered during this stage of life due to different influences. An adolescent's particular genetics, brain maturation and learning styles may allow him or her to make good decisions. Gender, age, race/ethnicity, religious and cultural identity and family and community values all impact the behavior of adolescents/ young adults.[23] Adolescents' resiliency is influenced by the settings in which they live; their connections to family and friends; and support from community institutions.[24] National surveys of thousands of young people reveal that the more protective factors or assets young persons possess, then the more likely they are to do well in school, less likely to engage in risk-taking behaviors and experience more resiliency. (See Table 2 for additional information on resilience factors)

Table 2

Resilience Factors That Protect Youth From Negative Life Experiences

Internal Factors

A young person has:

- Social competence – responsiveness to social cues, cultural flexibility, empathy communication skills and sense of humor
- Problem solving – capacity for planning, seeking help and critical and creative thinking
- Autonomy – sense of identity, self-awareness, ability to master tasks and distance oneself from negative messages and conditions
- Sense of purpose and belief in a bright future – goal directed, educational aspirations, optimism and tendency to have faith and spiritual connectedness
- Educational commitment – motivation to achieve, positive connection to school, school performance and homework
- Positive values – ideals such as helping people, concern for world hunger, caring about people's feelings and sexual restraint
- Social competencies – skills such as assertiveness, decision-making, friendship-making, planning; self esteem; and a positive view of the future

Environmental Factors

A young person is surrounded by:

- Caring relationships – relationships that convey compassion, understanding, respect and interest, that are grounded in listening
- Support – family and parents communicate and serve as social resources, parent involvement in school, positive school climate and adult relationships
- Strong, positive relationship with the father – significant for both genders, but especially females
- Ability to seek reassurance from peers – able to use friends as support for dealing with difficulties and as a sounding board for other possible points of view
- Messages conveying high expectations – firm guidance, structure and challenge, belief in the youth's innate resilience and recognition of strengths as opposed to problems and deficits
- Opportunities for meaningful participation and contribution – involvement in valued responsibilities, making decisions, giving voice and being heard and contributing talents to the community
- Structured time use –involvement in school, community and religious activities

Source: Adapted from R Jessor, ed., New Perspectives on Adolescent Risk Behavior, Cambridge University Press (1998); EE Werner and RS Smith, eds., Vulnerable but Invincible: A Longitudinal Study of Resilient Children and Youth, New York: McGraw-Hill (1982); and B Benard, Fostering Resiliency in Kids: Protective Factors in the Family, School and Community, Far West Laboratory for Educational Research and Development and the Western Regional Center for Drug-Free Schools and Communities (1991).

Youth Development

The philosophy and approach to policies and programs that incorporate the building of developmental assets and resiliency among youth is called the youth development approach. The underlying philosophy of youth development is holistic, preventive and positive, focusing on the development of assets and competencies in youth as the best means for fostering health and well-being and for avoiding negative choices and outcomes. Youth who succeed in the developmental tasks of adolescence lay the foundation for health and well-being in their adult lives.

The youth development framework or approach provides guidance about what young people need and what communities can provide to support optimal health and well-being:

- Youth are viewed as a valued and respected asset to society.
- Policies and programs focus on the evolving developmental needs and tasks of adolescents, and involve youth as partners rather than clients.
- Youth are supported by healthy relationships with adults and peers – these relationships provide a source of the emotional support, youth are provided guidance that nurtures their capacity to feel connected to others, navigate day-to-day life and engage in productive activities.
- Families, schools and communities are engaged in developing environments that support youth; this includes providing young people with stable places where they feel a sense of belonging, including home and community.

- Adolescents are provided opportunities to become involved in activities that enhance their competence, capacity, caring, character and civic engagement. These opportunities must help youth master skills and gain a sense of mastery. This results in an increasing sense of competence and productivity.
- Adolescents are provided an opportunity to experiment in a safe environment and to develop positive social values and norms.
- Adolescents are engaged in activities that promote self-understanding, self-worth, a sense of belonging and resiliency.[25, 26]

Best Practices

Best practices are those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying a risky/undesired health behavior or conversely, supporting and encouraging a healthy/desired behavior.

There are four broad areas that have been shown to effectively support the health and well-being of adolescents:

1. **Decreasing the risk factors** that will contribute to risky behaviors and poor health outcomes;
2. **Increasing the protective factors** that contribute to resiliency and healthy outcomes;
3. **Providing opportunities** for young people to successfully meet the developmental needs of adolescence; and
4. **Building healthy communities** that support and nurture adolescents.[27]

Best Practices - Programs

In addition, successful programs built on best practice research share a number of characteristics. This includes:

- **Target desired outcomes.** Successful programs clearly address the outcomes they seek to influence. In addition, these programs start early and maintain the effort over time. They move beyond the simplistic "one shot" approaches. Lastly, they are implemented with fidelity to tested strategies that have been shown to work.
- **Tailored to a specific target audience.** There must be a good fit between the program and the young people or families for whom it serves. This holds

whether a program is focused on prevention, intervention or treatment. For example, a program effectively addressing the needs of females of color, ages 15-18, living in an urban community, and staffed by females of the same racial or ethnic background will be different from a program reaching white males, ages 10-13, living in a suburban community.

- **Focus on building and sustaining relationships.** These relationships help provide young people with support and guidance that is essential to adolescent well-being. Adolescents need strong connections to caring, supportive adults and peers. This includes families, teachers, other adults and mentors. For example, mentors can offer friendship, guidance and assistance, and serve as positive role models. Teachers and other adults can serve as surrogate family members and role models. Effective programs address relationships either formally (e.g., mentoring programs) or informally.
- **Strengthen and support families of adolescents.** Parent-child relationships are vital to adolescent well-being. Teens that have warm, involved relationships with their parents are more likely to do well in school, have better social skills and have lower rates of risky sexual behavior than their peers. Teens whose parents demonstrate positive behaviors are more likely to engage in those behaviors. Parents who know about and monitor their teen's activities in age-appropriate ways have teens with lower rates of risky behaviors. Teens whose parents are caring and supportive, but who also consistently monitor them and enforce family rules, are more likely to be successful in school and to be psychologically and physically healthy. Siblings can also have an influence on adolescent health outcomes. [28]
- **Address peer influences.** Peer influences are important and can be positive. Adolescents often influence each other positively by modeling behaviors or pressuring each other to behave in certain ways.
- **Provide opportunities for young people to be involved and engaged.** These opportunities can range from after-school programs, recreational activities, community service and volunteer activities, educational opportunities, and more. These experiences provide a place for young people to learn and use critical life skills, build relationships and experiment in healthy ways. In addition, activities that take place during the high-risk hours of 3 p.m. to 8 p.m. give teens something positive to do and leave less time for getting into trouble.
- **Address youth issues from a positive approach.** Young people are viewed as resources to be nurtured by building skills and assets and providing opportunities. This is in comparison to programs that view youth as problems to be fixed. Successful programs use this approach whether they focus broadly on positive youth development, more targeted on prevention of health problems, or both. A positive approach is more likely to engage adolescents and help them realize their potential and avoid negative influences.

- **Engage youth as active partners in addressing critical issues.** Successful programs actively work to include youth as participants and influencers of program or public policy issues.[29]

Best Practices - Community Approaches

It is also important that adolescent health issues are addressed within the context of community collaboration and planning. These steps assume community and youth involvement.

- Develop a community-based assessment and

planning process to be sure that the community is addressing the adolescent issues that are most appropriate and pressing.

- Decide whether the issue will be addressed directly, or whether the conditions that make it possible will be changed.
- Locate practices or interventions that have successfully addressed the issue in the way the community wants it addressed.
- Determine what elements of a promising intervention will work in the community, and which ones need to be changed.
- Implement the intervention, making on-going adjustments as needed.
- Evaluate the work and results regularly, understanding that no matter how well any intervention works, it can always be improved.

When trying to identify a best practice or model program to meet the needs of an identified community, it is important to understand the community context to make an appropriate match. This involves conducting an environmental scan and a needs and assets assessment. Consider these questions when selecting a program model:

- What is it like for an adolescent to live in the community? An adolescent of color? An adolescent with special needs?
- What are the risk and protective factors that need to be addressed in the community?
- Who already provides services?
- Who are potential partners? Stakeholders? Allies? Opponents?
- How will the program fit with other activities in the community?[30]

End Notes

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